ADOBE SURGERY CENTER, P.C.
2585 N. Wyatt Drive
Tucson, Arizona 85712
Phone: (520)721-2728 Fax: (520)721-0179

Welcome Letter

Hello,

We at Adobe Surgery Center would like to welcome you to our facility. Below you will find detailed information regarding your surgery and what to expect throughout the entire process. Please take a few minutes to read the information carefully; when you check in for your surgery, you will be asked to sign a document confirming that you have read and understand the information contained in this brochure.

Adobe Surgery Center is solely owned and operated by Sam Moussa, MD. We are pleased that you have chosen us to take part in your healthcare, and would like to inform you that it is your right to receive care elsewhere in the community should you choose to do so. Please note that all physicians associated with our practice are licensed to practice in the State of Arizona and are credentialed and privileged to perform procedures in our facility.

While receiving care at our facility, you should know that we have adopted nationally recognized Patient Rights and Responsibilities and have enclosed a copy for your review. Information regarding our Health Initiative Portability and Accountability Act policy is also enclosed for your review. Additionally, copies of both are posted in our waiting room. If you have any advance directives that you would like added to your chart please provide these at the time of your procedure.

We also have available for your review, a copy of our Advance Directives/DNR Policy, Grievance Policy, Fees for Services, and Payment Policy, which are all located in our Patient Information Binder, located in the waiting room. If you would like a copy of these documents please feel free to take one.

After your procedure, should you have any questions or concerns after business hours please dial 911 for all emergencies, or you may contact the on-call physician directly at (520) 600-8804. Please note, our physician will only return calls that are directly related to a post-op concern. All other inquiries will receive a call back the following business day. Our hours of operation are Monday through Friday from 8:00 am to 5:00 pm. We are closed Saturday and Sunday and most major holidays. If you have any concerns, complaints, or comments regarding the quality of care you receive while in our facility, please contact Sam Moussa, MD Administrator or the Director of Nursing, at (520) 721-2728.

Should you have a concern or complaint that has not been satisfied by our staff, you may contact the Arizona Department of Health at (602)364-2536, or Medicare beneficiaries may contact the Health Services Advisory Group at (800) 841-1602.

By signing below you are acknowledging that you have received the above information and that all of your questions regarding this information have been answered to your satisfaction.

Thank you again for allowing us to take part in your healthcare.

Regards,
Adobe Surgery Center Staff

I have received information on the following

- ☐ ***Patients Rights and Responsibilities***
- ☐ ***HIPAA Notice of Privacy Practices***
- ☐ ***Advance Directives/Living Will, Healthcare Power of Attorney***
- ☐ ***Screening Colonoscopy vs. Diagnostic Colonoscopy***

Patient Name (please print) _____

Patient Signature_____Date_____

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MISSED PROCEDURE AND CANCELLATION POLICY

IF YOU ARE UNABLE TO KEEP YOUR SCHEDULED PROCEDURE APPOINTMENT, WE REQUIRE THAT YOU GIVE US A **TWO BUSINESS DAY** NOTICE TO INSURE THAT YOU ARE NOT CHARGED A FEE OF **$100.00** FOR THE MISSED APPOINTMENT.

Signature: _____ **Date:** _____

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SCREENING vs. SURGIAL/ DIAGNOSTIC COLONOSCOPY

A **SCREENING** Colonoscopy is defined as an initial colonoscopy procedure, or a procedure done every ten (10) years. If your procedure has been scheduled as a screening, and your procedure is uneventful, your procedure will remain as a screening, and you will not be required to return for another ten years.

If during your procedure polyps are found OR biopsies are taken THAT IS NO LONGER CONSIDERED A SCREENING COLONOSCOPY. The procedure is now considered a **SURGICAL/ DIAGNOSTIC COLONOSCOPY,** and this may change the processing of your claims.

If you had a previous colonoscopy and polyps were removed, or it has been less than ten years since your last colonoscopy, your procedure is **NOT** considered to be a screening. Your procedure is a **SURGICAL/ DIAGNOSTIC COLONOSCOPY.**

If you are having your procedure due to any symptoms such as a positive Cologuard test, change in bowel habits, change in bowel movements, diarrhea, constipation, bleeding, anemia, etc., your out-of-pocket expenses will be quoted as a **SURGICAL/ DIAGNOSTIC COLONOSCOPY**.

PLEASE CHECK WITH YOUR INSURANCE COMPANY PRIOR TO BEGINNING THE BOWEL PREPARATION.

Signature: _____ Date: _____

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ESOPHAGOGASTRODUODENOSCOPY (EGD)

ALL Upper Endoscopy Procedures (EGD's) are considered a **SURGICAL/ DIAGNOSTIC PROCEDURE.**

For an EGD there may be additional charges for pathology if biopsies are taken, dilation is performed during the procedure or brushings are done.

For Barrett's Esophagus the physician may require a brushing for a more accurate diagnosis.

As with **ALL SURGICAL/ DIAGNOSTIC PROCEDURES** your deductible and/or coinsurance will apply.

FOR MORE INFORMATION, PLEASE CONTACT YOUR INSURANCE COMPANY PRIOR TO ANY PROCEDURE.

Signature: _____ **Date:** _____

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Gastroenterology & Hepatology
Diplomates, American Board of Internal Medicine and Gastroenterology
Sam E. Moussa, MD * Douglas S. Peterson, MD * Howard M. Hack, MD

Thank you for choosing Adobe Surgery Center and Adobe Gastroenterology P.C.! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care. As a courtesy to our patients, we will contact your insurance company prior to your scheduled procedure and notify you in writing of any anticipated out of pocket expenses that will be due on the date of the appointment. But, **ultimately all charges incurred are patient responsibility**. Please understand that part of our contract with your insurance company states that we will collect all out of pocket expenses applied to you, the patient. We accept payment by cash, check, VISA, MasterCard, American Express and Discover.

If you are unable to pay all out of pocket expenses at the time of the procedure, please contact our billing department no less than two business days prior to your scheduled appointment to discuss possible payment arrangements.

If an arrangement is made and is not upheld on your part, your procedure will be rescheduled. Unfortunately this can cause unnecessary hardship to you as you may have already begun preparation for the procedure. If this happens a ***missed procedure appointment charge of $100*** will be assessed to you.

Patient Name: _____ Account #: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you, or your protected health information may be provided to a physician to whom you have been referred or seek counsel from, to ensure that physician has the necessary information to diagnose or treat you.

Treatment and office visits in our facility will require that you be called by name in the reception area. You will be asked personal and medical history questions by medical personnel to ensure safe and appropriate care in our surgery center. You may share a pre- or post-op area with other patients in our surgery center.

Obtaining approval or scheduling procedures or a hospital stay may require that your relevant protected health information be disclosed to the health plan or medical facility.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, medical studies, and conducting or arranging for other business activities. You may be greeted by name at our reception desk and ask to complete registration forms or sign consent for procedures. We may also call you by name in the reception area when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment or inform you of test results. We may contact you by telephone, E-mail, Postal Service or other forms of delivery services, as your doctor deems necessary.

Research: We may use and disclose medical information about our patients for research purposes, subject to the confidentiality provisions of state and federal law. Occasionally, researchers contact patients regarding their interest in participating in certain research studies. Enrollment in those studies can only occur after you have been informed about the study, had an opportunity to ask questions, and indicated your willingness to participate by signing a consent form.

When approved through a special review process, other studies may be performed using your medical information without requiring your consent. These studies will not affect your treatment or welfare, and your medical information will continue to be protected. For example, a research study may involve a chart review to compare the outcomes of patients who received different types of treatment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity and National Security; Workers' Compensation; Inmates, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Telephone calls to Adobe Gastroenterology/Surgery Center, P.C., may be monitored or recorded randomly, by management, for quality assurance or training purposes only.

Other Permitted and Required Uses and Disclosures: Will Be Made Only with Your Consent, Authorization or opportunity to object unless required by law.

Right to Request Restriction of PHI: If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. Effective March 26, 2013, The Omnibus Rule restricts provider's refusal of an individual's request not to disclose PHI.

Your Rights Regarding Your Health Information

You have the right to inspect and copy your protected health information. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes or information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. You must submit your request for medical records in writing to your Doctor.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request, in writing, must state the specific restriction requested and to whom you want the restriction to apply. (Please ask the receptionist for a form.)

Your physician is not required to agree to a restriction that you may request, unless you have requested a restriction on information disclosed to a health plan when you have covered the entire cost of service. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You also have the right to request, in writing, to receive confidential communications from us by alternative means or at an alternative location.

You may have the right to ask your physician to amend your protected health information. If you believe your medical record is incorrect or incomplete, you may request to amend your records through the use of an authorized amendment form. The original form must be placed into your medical file at this practice. You may request an amendment form from this office. Your request must be made in writing and submitted to your doctor at Adobe Gastroenterology, 2585 N. Wyatt Drive, Tucson, AZ 85712. The original information will also be retained in your file.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice. You then have the right to object or withdraw as provided in this notice.

Breach Notification Requirements: It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

Right to file a complaint: If you believe your privacy rights have been violated, you may file a complaint with us by notifying our HIPAA Compliance Officer. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before July 1, 2013.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. You may ask our office for a copy of this Notice at any time. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at (520) 721-2728.

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Patients' Rights and Responsibilities

Patient Rights:

- Adobe Surgery Center and medical staff have adopted the following statement of patient rights. This list shall include, but not be limited to, the patient's right to:
- Become informed of his or her rights as a patient in advance of, or when discontinuing, the provision of care. The patient may appoint a representative to receive this information should he or she so desire.
- Exercise these rights without regard to sex or cultural, economic, educational, or religious background or the source of payment for care.
- Considerate and respectful care, provided in a safe environment, free from all forms of abuse, neglect, harassment and/or exploitation.
- Access protective and advocacy services or have these services accessed on the patient's behalf.
- Appropriate assessment and management of pain.
- Remain free from seclusion or restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience, or retaliation by staff.
- Knowledge of the name of the physician who has primary responsibility for coordinating his/her care and the names and professional relationships of other physicians and healthcare providers who will see him/her.
- Receive information from his/her physician about his/her illness, course of treatment, outcomes of care (including unanticipated outcomes), and his/her prospects for recovery in terms that he/she can understand.
- Receive as much information about any proposed treatment or procedure as he/she may need in order to give informed consent or to refuse the course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate courses of treatment or nontreatment and the risks involved in each and the name of the person who will carry out the procedure or treatment.
- Participate in the development and implementation of his or her plan of care and actively participate in decisions regarding his/her medical care. To the extent permitted by law, this includes the right to request and/or refuse treatment.
- Formulate advance directives regarding his or her healthcare, and to have ASC staff and practitioners who provide care in the hospital comply with these directives (to the extent provided by state laws and regulations).
- Full consideration of privacy concerning his/her medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly.
- The patient has the right to be advised as to the reason for the presence of any individual involved in his or her healthcare.
- Confidential treatment of all communications and records pertaining to his/her care and his/her stay in the ASC. His/her written permission will be obtained before his/her medical records can be made available to anyone not directly concerned with his/her care.
- Receive information in a manner that he/she understands. Communications with the patient will be effective and provided in a manner that facilitates understanding by the patient. Written information provided will be appropriate to the age, understanding and, as appropriate, the language of the patient. As appropriate, communications specific to the vision, speech, hearing cognitive and language-impaired patient will be appropriate to the impairment.
- Access information contained in his or her medical record within a reasonable time frame (usually within 48 hours of the request).
- Reasonable responses to any reasonable request he/she may make for service.
- Leave the ASC even against the advice of his/her physician.
- Reasonable continuity of care.
- Be advised of the ASC grievance process, should he or she wish to communicate a concern regarding the quality of the care he or she receives or if he or she feels the determined discharge time is premature. Notification of the grievance process includes whom to contact to file a grievance, and that he or she will be provided with a written notice of the grievance determination that contains the name of the ASC contact person, the steps taken on his or her behalf to investigate the grievance, the results of the grievance and the grievance completion date.
- Be advised if facility/personal physician proposes to engage in or perform human experimentation affecting his/her care or treatment. The patient has the right to refuse to participate in such research projects. Refusal to participate or discontinuation of participation will not compromise the patient's right to access care, treatment, or services.

- Full support and respect of all patient rights should the patient choose to participate in research, investigation and/or clinical trials. This includes the patient's right to a full informed consent process as it relates to the research, investigation and/or clinical trial. All information provided to subjects will be contained in the medical record or research file, along with the consent form(s).
- Be informed by his/her physician or a delegate of his/her physician of the continuing healthcare requirements following his/her discharge from the ASC.
- Examine and receive an explanation of his/her bill regardless of source of payment.
- Know which ASC rules and policies apply to his/her conduct while a patient. ● Have all patient's rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.
- All personnel, medical staff members and contracted agency personnel performing patient care activities shall observe these patients' rights. Patient Responsibilities:
- The care a patient receives depends partially on the patient himself. Therefore, in addition to these rights, a patient has certain responsibilities as well. These responsibilities should be presented to the patient in the spirit of mutual trust and respect:
- The patient has the responsibility to provide accurate and complete information concerning his/her present complaints, past illnesses, hospitalizations, medications and other matters relating to his/her health.
- The patient is responsible for reporting perceived risks in his or her care and unexpected changes in his/her condition to the responsible practitioner.
- The patient and family are responsible for asking questions when they do not understand what they have been told about the patient's care or what they are expected to do.
- The patient is responsible for following the treatment plan established by his/her physician, including the instructions of nurses and other health professionals as they carry out the physician's orders.
- The patient is responsible for keeping appointments and for notifying the ASC or physician when he/she is unable to do so.
- The patient is responsible for his/her actions should he/she refuse treatment or not follow his/her physician's orders.
- The patient is responsible for assuring that the financial obligations of his/her hospital care are fulfilled as promptly as possible.
- The patient is responsible for following ASC policies and procedures.
- The patient is responsible for being considerate of the rights of other patients and ASC personnel.
- The patient is responsible for being respectful of his/her personal property and that of other persons in the hospital.

All surgery center personnel, medical staff members and contracted agency personnel performing patient care activities shall observe these patients' rights.

To report a complaint or grievance you may contact:
AzDHS – Licensing Services
150 N. 18th Ave., 4th floor
Phoenix, Az, 85007

Or call (602)364-2536.

You may also contact the Medicare Beneficiary Ombudsman at
www.medicare.gov/ombudsman/resourses.asp